METHOD FOR REIMBURSING INPATIENT HOSPITAL SERVICES

1. Hospitals paid using Prospective Payment System (PPS).

   a. In-state hospital service reimbursement paid to all hospitals and distinct part units, except those hospitals and distinct part units specifically identified in Section 2, will be made on the basis of a Prospective Payment System (PPS). The system generally follows the Medicare PPS in terms of the application of the system. Capital-related costs and medical education costs are excluded from the PPS and are paid on a reasonable cost basis.

   b. The base year used for the calculation of rates is the year ending June 30, 1992.

   c. Hospitals will be grouped into two groups based on the average number of Medicaid discharges for the years ended June 30, 1992, 1993 and 1994.

      (1) Group One - The base rate for a hospital with average discharges in excess of 100 per year will be based on the lower of actual cost or $2,155 but may not be less than $1,506.

      (2) Group Two - The base rate for a hospital with less than an average of 100 discharges per year will be $1,506.

   d. The DRG classification and grouper system is the same as used for Medicare as approved by HCFA. This system is updated annually.

   e. The DRG relative weights are calculated from North Dakota Medicaid data as of June 30, 1984 using the Medicare calculation methodology. DRG relative weights are compared annually for significant variances and adjustments may be made.

   f. An update factor is applied annually to the previous year's base rate. The update factor applied to the base year costs for the year effective July 1, 1995 is 12.9%. The update factor effective July 1, 1996 is 2.6% and for July 1, 1997 is 2.6%. Update factors for subsequent years will be equal to the update factor for PPS hospital operating payments determined annually by the Health Care Financing Administration and published in the federal register.

   g. Outlier Payments.

      (1) A cost outlier payment is made when costs exceed a threshold of two times the DRG rate or $15,000, whichever is greater. Costs above the threshold will be paid at 60 percent of billed charges.

(2) A day outlier payment is made when the length of stay for a recipient exceeds the lesser of the geometric mean length of stay plus twenty days or 1.94 standard deviations from the mean for any given DRG. Each day exceeding the threshold is paid at 60 percent of the per diem rate. The per diem rate is calculated as the hospital's basic DRG payment divided by the geometric mean length of stay.

(3) For DRG's 385-390 relating to neonates:

(a) The day outlier payment is calculated at 80% of the per diem rate once the thresholds in paragraph 2 are met; or

(b) The cost outlier thresholds are the greater of 1.5 times the DRG rate or $12,000. Costs above the threshold will be paid at 80 percent of billed charges.

(4) If the thresholds for both a cost outlier and a day outlier are met, only the day outlier payment method will apply.

g. Transfers. Payment will be the full DRG payment to the final hospital. Per diem payments will be made to the transferring hospitals. Total per diem payments to each hospital cannot exceed the full DRG payment. Per diem is the basic DRG payment divided by the geometric mean length of stay. More than one full DRG payment may be paid per case.

2. Hospitals paid based on reasonable costs.

a. Hospitals excluded from PPS are psychiatric, rehabilitation, long-term care, cancer and children's hospitals. Psychiatric and rehabilitation distinct part units are also excluded from PPS. Payments to these facilities are made based on a reasonable cost basis, using the Medicare methods and standards set forth in 42 CFR 413. An interim payment based on the Medicare cost to charge ratio will be made until such time as a cost settlement is made.

b. Indian Health Hospitals are paid at the published inpatient per diem rate.

3. Disproportionate Share Hospital (DSH) Adjustments.

a. Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive a DSH payment subject to any limitations set forth in this section.

b. The following criteria must be met before a hospital is determined to be eligible for a DSH payment adjustment.

(1) A hospital must have:

(a) A Medicaid inpatient utilization rate of at least 1% and at least one standard deviation above the mean

Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or a low-income inpatient utilization rate exceeding 25 percent; and

(b) At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid Plan. In the case of a hospital located in a rural area, (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures;

(2) A hospital which meets the criteria in Section 3.b(1)(a) but not 3.b(1)(b) is eligible if:

(a) The inpatients of a hospital are predominantly individuals under 18 years of age; or

(b) The hospital did not offer non-emergency obstetric services as of December 21, 1987; or

(3) A state-owned psychiatric hospital is eligible if the hospital's Medicaid inpatient utilization rate exceeds 1%.

c. The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period.

d. The low-income utilization rate is the sum (expressed as a percentage) of the fraction, calculated as follows:

(1) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such case subsidies) in the same cost reporting period; and,

(2) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts

(other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that is, reductions in charges given to other third-party payers, such as HMO's, Medicare or Blue Cross.

e. A hospital which wishes to be considered for disproportionate share payments based on a low income utilization rate must submit, annually, a request indicating this desire and information sufficient to enable the computation of the low income utilization rate by April 1.

f. For the purpose of paying disproportionate share hospitals, there are three types of hospitals, hospitals paid using PPS; the state psychiatric hospital; and all other hospitals paid based on reasonable costs.

g. DSH payment adjustments are calculated as follows:

(1) Eligible hospitals paid using PPS will receive a DSH payment adjustment equal to one percent plus an additional one-tenth of one percent for each percentage point that the hospital's Medicaid utilization rate exceeds one standard deviation above the state's mean inpatient utilization rate for all hospitals receiving Medicaid payments. The eligible hospital's base DRG payment for the quarter being reported on form 64 will be multiplied times the DSH adjustment percentage to determine the DSH adjustment payable quarterly. Beginning July 1, 1995 the DSH payment adjustment will be increased to 4% plus an additional four-tenths of one percent for each percentage point that the hospital's Medicaid utilization rate exceeds one standard deviation from the mean.

(2) Eligible hospitals paid on based reasonable costs, excluding the state psychiatric hospital, will receive a DSH payment adjustment equal to $1.00 plus one-tenth of one percent for each percentage point that the hospital's Medicaid utilization rate exceeds one standard deviation above the state's mean inpatient utilization rate for all hospitals receiving Medicaid payments. The eligible hospital's actual interim payments for the quarter being reported on form 64 will be multiplied times the DSH adjustment percentage to establish the hospital's DSH payment adjustment. The DSH payment adjustment is final and no recoupment or additional payment for DSH will be made when a settlement of the interim payment to reasonable cost is made.

(3) If eligible, the state psychiatric hospital will receive a DSH payment adjustment calculated as an amount equal to $1.00 plus the state's disproportionate share allotment

less the quarterly DSH payment adjustments made to all other eligible hospitals. The DSH payment adjustment to the state hospital will be made quarterly. The quarterly payment will be calculated by dividing the state's annual disproportionate share allotment by four and subtracting all disproportionate share payments made to other eligible hospitals in that quarter. Any adjustments to the state's disproportionate allotment will be corrected in the quarter the adjustment is made.

h. DSH payment adjustments will be limited as follows:

(1) Effective July 1, 1995 the DSH payment adjustment for any eligible hospital may not exceed the greater of the total of the unreimbursed costs of providing services to Medicaid recipients and of providing services to uninsured patients or the limitations set forth in section 1923(g) of the Act.

(2) If requested by the department, eligible hospitals must submit information on unreimbursed costs of providing hospital services to Medicaid recipients and of providing hospital services to uninsured patients before a DSH payment adjustment can be made.

(3) Total DSH payment adjustments paid to all eligible hospitals may not exceed the state's DSH allotment.

4. Out-of-State Inpatient Hospital Service Payments.

a. Out-of-state hospital service payments, except as identified below, will be paid based on the lower of billed charges or the Medicaid rate payable, at the time services were rendered, by the state in which the hospital is located. Such rates are requested of the other state when a claim for inpatient care is received from a hospital in another state. Payment to out-of-state facilities is considered as a final payment and no retroactive adjustments to payments will be made for subsequent changes in the base Medicaid rates.

b. University of Minnesota Hospitals, Minneapolis, Minnesota, will be reimbursed for organ transplants based upon a payment methodology negotiated by the hospital and the Medicaid Agency.

5. Inpatient Psychiatric Services for Individuals Under 21.

a. Payments for inpatient psychiatric services for individuals under twenty-one in residential treatment centers will be made using a prospective payment system developed by the state specifically for residential treatment centers as set forth in North Dakota Administrative Code, 75-02-09.

6. Payment for inappropriate level of care days provided in an inpatient hospital setting will be made at the statewide average nursing facility rate effective January 1 of each calendar year or the average of the rates for non-state owned intermediate care facilities in effect on January 1 of each year. Payment is available only if the following criteria are met:

   a. The individual must be screened in need of nursing facility or intermediate care for the mentally retarded services using the level of care criteria applicable to nursing facilities or intermediate care facilities for the mentally retarded;

   b. Services must not be otherwise available;

   c. The hospital may not be participating as a swing bed hospital; and

   d. The criteria in paragraph a and b must be redetermined and met every 90 days following the initial determinations required in paragraphs a and b.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.